2015 Bariatric Surgery Pilot Program SHBP Member Application

To be eligible to apply for the 2015 benefit year, you must meet and agree to all the requirements outlined in Sections A & B. ***This application must be submitted no earlier than January 2, 2015 & postmarked no later than February 2, 2015****.*

Section A

The name and following information of the applicant (please print clearly):

- Employee name and SSN_____
- Applicant name _____
- Applicant SHBP member ID card number (if known) _____
- Applicant date of birth_____
- Applicant address_____
- Applicant home phone and cell_____
- Applicant email address_____

You must agree to and meet all the following SHBP eligibility and participation requirements:

1. You must have completed and submitted this 2015 Bariatric Surgery Pilot Program Member Application.
2. SHBP is primary insurance for you.
3. You do not use tobacco.
4. You must be covered under SHBP as your primary insurance for two years immediately prior to submission of this application.
5. You have completed the required on-line 2015 health assessment.
6. You have not had previous bariatric surgery.
7. You must consent to provide personal and medical information as requested by the SHBP or its plan administrator.
8. You must agree to enroll in a 24-month post-operative SHBP case management program which requires regular calls with nurse case manager.
9. You must intend to continue coverage under SHBP for two years following the approved surgical procedure date.
10. You must comply with any and all requests by the SHBP for postsurgical medical and productivity information, and such agreement shall survive your Plan participation in the SHBP.

By signing, you certify that you meet the above 2015 Bariatric Surgery Pilot Program eligibility requirements (above items 1-7), and if randomly selected, you will receive a required multi-disciplinary health evaluation with a metabolic and bariatric surgeon. If surgical authorization is given by your medical claims administrator, you agree to comply with all the above eligibility and participation requirements.

Applicant signature_____**Date**_____

Section B (this section may be completed by your personal physician prior to January 1, 2015)

Applicant referring physician and contact information (please print clearly):

- Physician name_____
- Physician address_____
- Physician telephone_____

Physician certification for the applicant named in Section A:

1. My patient has a body mass index (BMI) greater than 40, **or**
2. My patient has a BMI greater than 35 with one or more co-morbidities (such as diabetes, hypertension, gastro-esophageal reflux disease, sleep apnea, or asthma) **and**
3. My patient does not use tobacco.

By signing, I certify that my patient meets the above clinical criteria in Section B:

Physician signature _____**Date**_____

Important Note: We anticipate a large number of applications for benefit year 2015. Please understand by submitting the 2015 Bariatric Surgery Pilot Program SHBP Member Application within the timeframe does not guarantee that you will be one of the 75 pilot participants randomly selected for benefit year 2015. After selection, eligibility and prior authorization criteria must also be met. Surgical authorizations for pilot program year 2015 are valid for surgery performed by December 31, 2015. Regardless of extenuating circumstances, no exceptions will be made for extending approvals beyond the benefit year.

For internal use: Date application postmarked: _____ **Date received:** _____